PEIA MEDICAL HOME PROGRAM

Medical Home Physician Selection Form

Policyholder Name: _____ Address: _____

ID Number: _____ _____

Insured Effective Date: _____ _____

Daytime Phone: _____

Covered Individual	Date of Birth	Relationship Code	Medical Home Physician Number from enclosed Provider Directory

Please Note: This is not an open enrollment. If you have more dependents than those listed or if any of the information is incorrect, please obtain a change-in-status form from your benefit coordinator or PEIA to make corrections.

POLICYHOLDER SIGNATURE _____ **DATE** _____

Please return this form to: Public Employees Insurance Agency, Attn: Medical Home Program, 601 57th St., SE, Suite 2, Charleston, WV 25304-2345.

Coverage in the Medical Home Program will be effective on the first day of the month following the month we receive your medical home physician selection form.